MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09604

CERTIFICATE OF DEATH

09609

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS: Susquehanna Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herman — Middle: Alexander — Last:
4. DATE OF DEATH: Month: July — Day: 29 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 2, 1893
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Penna. R.R.
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: John Alexander
14. MOTHER'S MAIDEN NAME: Anna [redacted] Frederick
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 716-12-2832
17. INFORMANT: Estella B. Alexander — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Exanition — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Carcinomatosis — 2 months
DUE TO (c): Ca of Gall bladder — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1551

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Calculous cholecystitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 21, 1967, to July 29 1967, that (I) (we) last saw the deceased alive on July 29 1967, and that death occurred at 4 A M, from causes and on the date stated above.

22a. SIGNATURE: A.W. Grigoleit M.D. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/29/67
22c. PHYSICIAN'S NAME (Type): A.W. GRIGOLEIT
22d. ADDRESS: Havre de Grace

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 1, 1967
23c. NAME OF CEMETERY OR CREMATORY: Abingdon ME Cemetery
23d. LOCATION (City or Town) (County) (State): Abingdon, Maryland.
24. FUNERAL DIRECTOR: Lee A. Patterson & Son — ADDRESS: Perryville, Md.
25d. REC'D BY REGISTRAR DATE: AUG 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09605 09610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 5 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MARYLAND AVE AND BARRETT ST.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
d. STREET ADDRESS: MARYLAND AVE AND BARRETT ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CHARLES — Middle: ALLEN — Last: ANDERSON

4. DATE OF DEATH: Month: JULY — Day: 31 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: FEB. 13, 1894

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BANK TELLER

10b. KIND OF BUSINESS OR INDUSTRY: BANKING

11. BIRTHPLACE (County & State, or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GEORGE M. ANDERSON

14. MOTHER'S MAIDEN NAME: EMMA BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-05-3743

17. INFORMANT: Mrs. IRENE W. ANDERSON, Address: HAVRE DE GRACE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Sigmoid

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan., 19 67 to July 31, 19 67, that (I) (we) last saw the deceased alive on July 31, 19 67, and that death occurred at 12 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John D. Yun M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/2/67

22c. PHYSICIAN'S NAME (Type): JOHN D. YUN

22d. ADDRESS: HAVRE DE GRACE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: AUG 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: WEST NOTTINGHAM CEM.

23d. LOCATION (City, town or county) (State): CECIL Co. MD

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R. Madison Mitchell, Havre de Grace, Md

25a. REC'D BY REGISTRAR DATE: AUG 4 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09606 09611

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY, OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace, Md.
d. STREET ADDRESS: 810 Giles St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: E. — Last: Baker
4. DATE OF DEATH: Month: July — Day: 27 — Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 17 1893
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Billing Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George W. Williams
14. MOTHER'S MAIDEN NAME: Caroline Kohee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 218-46-0550
17. INFORMANT: W. Ernest Baker — Address: 810 Giles St Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 11 days
DUE TO (b): Arteriosclerotic Heart disease — 2 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from July 19 1967 to July 27, 1967, that (I) (we) last saw the deceased alive on July 27 1967, and that death occurred at 10:10 A.M. from causes and on the date stated above.

22a. SIGNATURE: Emma L. Wadsworth M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: July 30, 1967
23c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.
23d. LOCATION (City or Town) (County) (State): Cecil Co. Md

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: Havre de Grace, Md.
25a. REC'D BY REGISTRAR DATE: JUL 31 1967
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09607

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09612

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dan H Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Havre de Grace 21001
d. STREET ADDRESS: 410 N. Union Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul — Middle: R. — Last: Barnaby
4. DATE OF DEATH: Month: July — Day: 16 — Year: 1967
5. SEX: M.
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 18, 1891
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): B & O. Railroad
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (State or foreign country): IND.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: REV. ALTON P. BARNABY
14. MOTHER'S MAIDEN NAME: UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 350-10-1938
17. INFORMANT: Mrs. Mary E. Barnaby — Address: 410 N. Union Ave Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Noturol causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Bel Air, Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 7-17-67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: July 19 1967
23c. NAME OF CEMETERY OR CREMATORY: HARMONY PRESBYTERIAN CH. YD.
23d. LOCATION (City or Town): HARFORD (County): Co. (State): MD.

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: Havre de Grace, Md.
25a. REC'D BY REGISTRAR DATE: JUL 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09608 Item 2 See birth certificate and 05013 09613

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: ~~MA~~ Florida
b. COUNTY: ~~Harford~~ Orange
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Apopka ~~Aberdeen Proving Ground~~ 48-3
d. STREET ADDRESS: 9 West 18th Street ~~Post Guest House~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Darrow	None	Barnes	July	10	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	Neg		9 July 1967	yrs.			9	29

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	N/A	Harford, Co. Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Windell Barnes	Marilyn Lawrence

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	-	-	Father (Same as Above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress Syndrome — INTERVAL BETWEEN ONSET AND DEATH

7735

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b) Prematurity (33 weeks)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from 9 July, 1967, to 10 July, 1967, that (I) (we) last saw the deceased alive on 10 July 1967, and that death occurred at 800A M, from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22b. DATE SIGNED
[signature]					10 July 1967

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
WILLIS H. STEPHENS JR, CPT, MC	Kirk Army Hospital, APG Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Removal	July 12-1967	Washington Shore Cem.	Orlando, Florida

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Walter McConkey Jr. Tarring Funeral Home Aberdeen, Md. 21001	JUL 12 1967	J. Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C9609 C9614

1 PLACE OF DEATH
a COUNTY Harford MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington
c LENGTH OF STAY In 1b 19 YRS.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Poole Road

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE Md.
b COUNTY Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington
d STREET ADDRESS Poole Road
e IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print) First: Frances Middle: E. Last: Cass
4 DATE OF DEATH Month: July Day: 30 Year: 1967
5 SEX F
6 COLOR OR RACE W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH 11-6-08
9 AGE (In years last birthday) 58 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) DARLINGTON, MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME John H. Price
14 MOTHER'S MAIDEN NAME Martha Amoss

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16 SOCIAL SECURITY NO 215-32-8091
17 INFORMANT Robert H. McCass Address: Darlington, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Asphyxia due to CO
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Rec'd in closed garage
20c TIME OF INJURY Month, Day, Year Hour o m p m 7-30-67
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f (City or town) Darlington (County) Hd. (State) Md.

21 I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type) Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) Bel Air, Md.
22. DATE SIGNED 8-1-67

23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b DATE THEREOF Aug. 2, 1967
23c NAME OF CEMETERY OR CREMATORY Darlington
23d LOCATION (City or Town) Darlington (County) Md. (State)

24 FUNERAL DIRECTOR John H. Harbine ADDRESS Delta, Pa.

25a RECD BY REGISTRAR DATE AUG 2 1967
25b REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C96'0 Items #2b & 9 Fil 391 7/2 /67 ph

CERTIFICATE OF DEATH

C3615

1. PLACE OF DEATH a. COUNTY: Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brevin Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 66 Ostego St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Ora Middle: Mary Last: Chance

4. DATE OF DEATH Month: July Day: 19 Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Dec 28, 1883
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Schuresbanding
12. CITIZEN OF WHAT COUNTRY? USA America

13. FATHER'S NAME: David Hawkins
14. MOTHER'S MAIDEN NAME: Laura Hopkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 219-20-6043
17. INFORMANT: Mrs. Melvin Macklin Address: 800 S. Adams, Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

	Cause	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	5 days
DUE TO (b)	debility, CVA	4 yrs
DUE TO (c)	arteriosclerotic, hypertensive cardiovascular disease	10 yrs

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 20, 1966, to July 19, 1967, that (I) (we) last saw the deceased alive on July 19 1967, and that death occurred at 2 P M, from causes and on the date stated above.

22a. SIGNATURE: Edward J. Simon M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-20-67
22c. PHYSICIAN'S NAME (Type): EDWARD J. SIMON
22d. ADDRESS: HAVRE DE GRACE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 7/22/67
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill
23d. LOCATION (City or Town) (County) (State): Havre de Grace Md

24. FUNERAL DIRECTOR: Pennington ADDRESS: Havre de Grace Md
25a. REC'D BY REGISTRAR DATE: JUL 24 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09611 — 0816

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 48 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Md — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: 23 High St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Alice — Middle: Moran — Last: Charsha
4. DATE OF DEATH: Month: 7 — Day: 24 — Year: 1967
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-1-1907
9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundry
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Hy, Perry Point, Md
11. BIRTHPLACE (County & State, or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Moran
14. MOTHER'S MAIDEN NAME: Hanna Barron

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 212-28-7606
17. INFORMANT Address: Clarence Moran, New Haven, Conn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cranition & Dehydration — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): Colo-duodenal fistulae — 3 weeks
DUE TO (c): Ca Transverse colon — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-7-67, 19 to 7-24, 19 67 that (I) (we) last saw the deceased alive on 7/24 1967, and that death occurred at 9:05 A M, from causes and on the date stated above.

22a. SIGNATURE: A.W. Grigoleit — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/25/67
22c. PHYSICIAN'S NAME (Type): A.W. GRIGOLEIT
22d. ADDRESS: HAVRE de GRACE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-26-67
23c. NAME OF CEMETERY OR CREMATORY: Hopewell Cemetery
23d. LOCATION (City or Town) (County) (State): Port Deposit Md

24. FUNERAL DIRECTOR: Lee C. Patterson — ADDRESS: Darlington, Md
25a. FILED BY REGISTRAR DATE: AUG 2 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09612

CERTIFICATE OF DEATH

0617

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 18 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brevin Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MYRTLE Middle . Last CHEEK

4 DATE OF DEATH: Month July Day 20 Year 19 67

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Aug.12,1877

9 AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State, or foreign country): Sparta,N.C.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Jennings

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16 SOCIAL SECURITY NO.: None

17. INFORMANT: Clay J.Cheek, Address Street,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion, terminating — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Chronic arterio-sclerotic Cardio-Vasc. Disease — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1957, to July 20, 1967, that (I) (~~was~~) last saw the deceased alive on July 20, 1967, and that death occurred at 8:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Willard P. Hudson M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: July 21,1967

22c. PHYSICIAN'S NAME (Type): Willard P. Hudson M.D.

22d ADDRESS: Forest Hill,Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: July 23,1967

23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion

23d LOCATION (City or Town) (County) (State): Belair,Harford Co.,Md.

24. FUNERAL DIRECTOR: John H. Hardina

ADDRESS: Delta,Penna.

25a REC'D BY REGISTRAR DATE: JUL 25 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

.9613 — 33613

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY: HARFORD — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND — b. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~KEERMEEN~~, HAVRE DE GRACE, — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CITIZEN'S NURSING HOME	d. STREET ADDRESS: 37 Mount Royal Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
FLORENCE	A.	CONKLING	07-	29	19 67

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
F	W		10-13-1889	77 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	Home	VIRGINIA	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Leighton C. Acree	Florence L. Royall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
No	216-44-1472	Lester J. Conkling, Same as 2 C & D.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY.

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory arrest	Hrs
DUE TO (b)	Cerebral Arteriosclerosis	1 yr
DUE TO (c)	Recurrent Cerebral thrombosis	6 mos

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 6/30, 19 67, to 7/29, 19 67, that (I) (we) last saw the deceased alive on 7/28 19 67, and that death occurred at 9:45 M, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22b. DATE SIGNED
Charles J. Foley Jr.		7-29-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
CHARLES J. FOLEY JR	H. de GRACE, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2 Aug. 67	Churchville Presbyterian Cem.	Churchville, Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tarring Funeral Home	Aberdeen, Md.	AUG 1 1967	Frances Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

29614 — 09519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1/20/67 to 7/27/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun, Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MARY — Middle: Elizabeth — Last: Crothers.

4. DATE OF DEATH: Month: 7 — Day: 26 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: 9/2/1891

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (County & State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Jordan

14. MOTHER'S MAIDEN NAME: Mary (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ———

16. SOCIAL SECURITY NO.: 214-46-9759

17. INFORMANT Address: Mrs. Adelaide C. McCardell, Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ca. of esophagus c metastasis — INTERVAL BETWEEN ONSET AND DEATH: 10 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): —
DUE TO
(c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): A.S.C.V.D.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 20th 1967, to July 27 1967, that (I) (we) last saw the deceased alive on July 27th 1967, and that death occurred at ____ M, from causes and on the date stated above

22a. SIGNATURE: Edward C. Loo M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/27/67

22c. PHYSICIAN'S NAME (Type): Edward Loo M.D.

22d. ADDRESS: 211 N. Union Ave., Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-30-1967

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION (City or Town) (County) (State): Port Deposit, Maryland.

24. FUNERAL DIRECTOR: Lee A. Patterson

ADDRESS: Perryville, Maryland.

25a. REC'D BY REGISTRAR DATE: AUG 2 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09615 09620

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 583 Cressy Road

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 583 Cressy Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: WILLIAM Middle: Robert Last: FOUSE

4. DATE OF DEATH: Month: July Day: 10, Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 26, 1921

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supply Clerk

10b KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11 BIRTHPLACE (State or foreign country): Marion, Smythe Co, Virginia

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Patterson Fouse

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) 1942-1964

16. SOCIAL SECURITY NO: 223-28-6442

17 INFORMANT (Wife) 838-8132: Mrs. Jean M. Fouse — Address: 583 Cressy Rd. Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Electrocution
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
114.0
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): apparently by defective live electric wire

20c TIME OF INJURY Month, Day, Year: Hour 6 p.m. 7/10 19 67

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f (City or town) Bel Air (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

22. DATE SIGNED: 7/11/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 13, 1967

23c NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d LOCATION (City or Town) Bel Air (County) Harford (State) Maryland 21014

24 FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25a RECEIVED BY REGISTRAR DATE: JUL 13 1967

25b REGISTRAR'S SIGNATURE: Charles Young

VR A15ME (5) 6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

99616

CERTIFICATE OF DEATH

C5621

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 7 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Belair
d. STREET ADDRESS: 201 N. View Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: EARNest — Middle: GREGORY — Last: GERDOM

4. DATE OF DEATH: Month: July — Day: 13 — Year: 1967

5 SEX: Male

6 COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Aug. 12, 1909

9 AGE (In years last birthday): 57 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electronic (Tech.)

10b KIND OF BUSINESS OR INDUSTRY: U.S Govt. ~~Tech.~~ Electronic

11 BIRTHPLACE (County & State, or foreign country): Millville, New Jersey

12 CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME: Clarence G. Gerdom (D)

14. MOTHER'S MAIDEN NAME: Grace Jewell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ~~Yes~~ (If yes give war or dates of service): Korean

16 SOCIAL SECURITY NO: 220-22-0355

17 INFORMANT: Wife, Same as 2 C & D — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cremia, due to — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Secondary Cremia — 2 wks
DUE TO (c): Adenocarcinoma Rectum Cinoperalle — 22 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1274X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour o m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from ____, 19__, to July 13, 1967, that (I) (we) last saw the deceased alive on July 13 1967, and that death occurred at 12:58 p M, from causes and on the date stated above

22a. SIGNATURE: J. Ralph Horky, M.D.
M.D ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/14/67

22c PHYSICIAN'S NAME (Type): J. Ralph Horky, M.D.

22d ADDRESS: Churchville, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 16 July 67

23c NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens,

23d LOCATION (City or Town) (County) (State): Aberdeen, Maryland

24. FUNERAL DIRECTOR: Walter Macomber Sr.

ADDRESS: Tarring Funeral Home, Aberdeen, Maryland

25a. REC'D BY REGISTRAR DATE: JUL 17 1967

25b REGISTRAR'S SIGNATURE: Florence Jones

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09617

CERTIFICATE OF DEATH

09623

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 6 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CITIZENS NURSING HOME

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MD. — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - STREET
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First: Mildred — Middle: F. — Last: Greenwood

4. DATE OF DEATH: Month: JULY — Day: 11, — Year: 1967

5 SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8 DATE OF BIRTH: APRIL 30, 1894

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State or foreign country): MEDFORD, MASS.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CLIFFORD H. BUTTRICK

14. MOTHER'S MAIDEN NAME: BLANCHE PARKER

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16 SOCIAL SECURITY NO.:

17. INFORMANT Address: MRS. EDWARD H. SEDRING, STREET, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): A.S.C.V.D.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3-4 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Aspiration Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 30, 1967 to July 11, 1967 that (I) (we) last saw the deceased alive on July 6, 1967, and that death occurred at 9:00 M. from causes and on the date stated above

22a. SIGNATURE: Edward C. Leeds M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/11/67

22c. PHYSICIAN'S NAME (Type): Edward C. Leeds M.D.

22d. ADDRESS: Havre de Grace, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: JULY 15, 1967

23c. NAME OF CEMETERY OR CREMATORY: ASCENSION

23d. LOCATION (City or Town) (County) (State): STREET, MD.

24. FUNERAL DIRECTOR: John H. Harkins — ADDRESS: DELTA, PA.

25a. REC'D BY REGISTRAR DATE: JUL 17 1967

25b REGISTRAR'S SIGNATURE: Gladys Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

4 1

FOR STATE HEALTH DEPT. (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23618 — 1523

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d. STREET ADDRESS: 1818 Magnolia Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Beverly — Middle: Ann — Last: Hash

4. DATE OF DEATH: Month: July — Day: 5 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 19, 1946

9. AGE (In years last birthday): 20 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector

10b. KIND OF BUSINESS OR INDUSTRY: Ordnance Prod.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William J. Hash, Sr.

14. MOTHER'S MAIDEN NAME: Viola Waters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-48-6101

17. INFORMANT: Mrs. Darlyne Belcher, 800 Barry Lane, Joppa Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture Skull
1.04
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Auto Accident

20c. TIME OF INJURY Month, Day, Year: Hour 2 a.m. p.m. — 7-5 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State): Havre de Grace Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Baltimore
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 7-5-67
EXAMINER'S NAME (Type): Gerald E Palmer M.D.
Address (Street, city, town, or county):

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City, town or county) (State): Bel Air Harford Md.

24. FUNERAL DIRECTOR: Howard R. McComas & Son, ADDRESS: Abingdon, Md. 21009

25a. REC'D BY REGISTRAR DATE: JUL 7 1967
25b. REGISTRAR'S SIGNATURE: Florence Yingst

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (3) 5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09619

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03824

FOR STATE HEALTH USE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b: DOA
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bradshaw
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FRANK — Middle: DAVID — Last: HAYNES

4. DATE OF DEATH: Month: July — Day: 25 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 6, 1919

9. AGE (In years last birthday): 48 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Joppa, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Haynes

14. MOTHER'S MAIDEN NAME: Eva Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Louise Gibson, 721 Broadway, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Asphyxia due to Drowning — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Drowned

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m.: July 25 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Susquehanna River

20f. (City or town) (County) (State): Havre de Grace Harford Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D.
EXAMINER'S NAME (Type): Gerald E Palmer, MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Bel Air, Md
22. DATE SIGNED: 7-25-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 29, 1967
23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
23d. LOCATION (City or Town) (County) (State): Lorely Balto Md

24. FUNERAL DIRECTOR — ADDRESS: Howard K. McComas & Son, Abingdon, Md.

25a. RECD BY REGISTRAR — DATE: JUL 31 1967

25b. REGISTRAR'S SIGNATURE: Florence Jones

VR A15ME (5)
6M 1/66

1 2

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09620

CERTIFICATE OF DEATH

09625

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
d. STREET ADDRESS: 2113 Battle Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mildred — Middle: B. — Last: Henson
4. DATE OF DEATH: Month: 7 — Day: 24 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-14-24
9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months: 10 — Days: 10
IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (County & State or foreign country): Gravelly Hill, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Bond
14. MOTHER'S MAIDEN NAME: Lida Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215-34-6312
17. INFORMANT: Mr. Andrew J. Henson, Jr. Address: 2113 Battle St. Edgewood, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 3-4 hrs.
DUE TO (b): Carcinomatosis — 7 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Breast Carcinoma — 39 mos.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____, 19___, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: Charles J. Foley Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/25/67
22c. PHYSICIAN'S NAME (Type): CHARLES J. FOLEY JR.
22d. ADDRESS: HAVRE DE GRACE Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-29-67
23c NAME OF CEMETERY OR CREMATORY: Mt. Zion Methodist Cem
23d LOCATION (City or Town) (County) (State): Joppa, Harford Co. Md

24. FUNERAL DIRECTOR ADDRESS: Otelia J. Bullock, Havre de Grace Md. 21078
25a. REC'D BY REGISTRAR DATE: JUL 28 1967
25b. REGISTRAR'S SIGNATURE: Frances Yingst

1 —5

09621 Item #8 Film #331 7/7/67 ph 00926

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY: HARFORD, MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground

c. LENGTH OF STAY IN 1b: 4 Days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

d. STREET ADDRESS: 21 Joseph Gallegher St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Pete Middle: Last: Hook

4. DATE OF DEATH Month: July Day: 23 Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5 July 1916

9. AGE (In years last birthday): 51 yrs | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (County & State, or foreign country): St. Francis, Mo

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Deceased

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes 19Jan66-23Jul67

16. SOCIAL SECURITY NO.: 490331449

17. INFORMANT: US ARMY PERSONNEL RECORDS Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

	Cause	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Peritonitis, Generalized	2 Days
DUE TO (b)	Abcess, Retroperitoneal, Left	4 Days
DUE TO (c)	Diverticulitis, Ruptured	5 Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fatty Liver, Card[redacted]

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) XXXXXX attended the deceased from 20 July, 1967, to 23 July, 1967, that (I) (we) last saw the deceased alive on 23 July 1967, and that death occurred at 1112PM, from causes and on the date stated above.

22a. SIGNATURE: Curtis I. Johnson M.D. M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 25 July 1967

22c. PHYSICIAN'S NAME (Type): CURTIS I. JOHNSON, CPT MC

22d. ADDRESS: Kirk Army Hospital, Aberdeen PG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 27, 1967

23c. NAME OF CEMETERY OR CREMATORY: All Saints Cemetery

23d. LOCATION (City or Town) (County) (State): New Castle County, Delaware

24. FUNERAL DIRECTOR: Lee H. Patterson & Son ADDRESS: Perryville, Md.

[signature], Perryville, Md

25a. REC'D BY REGISTRAR DATE: JUL 28 1967

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

1

FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09622

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09527

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 9 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
d. STREET ADDRESS: 704 TuPelo Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JAMES — Middle: E. — Last: JONES

4. DATE OF DEATH: Month: July — Day: 24, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 11, 1917

9. AGE (In years last birthday): 50 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Sta. Attendant

10b. KIND OF BUSINESS OR INDUSTRY: auto service

11. BIRTHPLACE (State or foreign country): Somerset, Kentucky

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Everett Jones

14. MOTHER'S MAIDEN NAME: Margaret Dugger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 207-14-0204

17. INFORMANT: Mrs. Mildred N. Jones — Address: Edgewood, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I — DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Subacute Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] MD

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

22 DATE SIGNED: 7/24/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 26, 1967

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cemetery

23d. LOCATION (City or Town): Baltimore (County): (State): Md

24. FUNERAL DIRECTOR — ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009

25a. RECEIVED BY REGISTRAR — DATE: JUL 27 1967

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15ME (5)
6M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09623 Item 2 See birth cert. 8-4-67 ams

CERTIFICATE OF DEATH

68628

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: ~~Maryland~~ Georgia
b. COUNTY: ~~Harford~~ Bibb
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Aberdeen Proving Ground~~ Macon
d. STREET ADDRESS: ~~1115 Triple Hill Drive~~ 2767-B Rodman Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Brenda — Middle: Anne — Last: Jordan

4. DATE OF DEATH: Month: July — Day: 19 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: CAU

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1 Feb 67

9. AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months: 5 — Days: 18 — Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Harford, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lawrence W. Jordan

14. MOTHER'S MAIDEN NAME: Yvonne Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: N/A

17. INFORMANT: Father — Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Chronic congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: since 6 weeks of age
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Congenital Heart Disease — since birth
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Aspiration of Feeding

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~XX~~(this hospital) attended the deceased from 12 June, 19 67, to 19 July, 19 67 that (I) ~~(we)~~ last saw the deceased alive on 19 July 19 67, and that death occurred at 0325 AM, from causes and on the date stated above

22a. SIGNATURE: Thomas G Kirkhope — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ M.D.

22b. DATE SIGNED: 19 July 67

22c. PHYSICIAN'S NAME (Type): THOMAS G. KIRKHOPE, CPT, MC

22d. ADDRESS: Kirk Army Hospital, Aberdeen PG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 20 July 67

23c. NAME OF CEMETERY OR CREMATORY: Andersonville Nat. Cem.

23d. LOCATION (City or Town) (County) (State): Andersonville, Ga.

24. FUNERAL DIRECTOR: Otha L Tarring — ADDRESS: Tarring Funeral Home Aberdeen, Md.

25a. RECD BY REGISTRAR DATE: JUL 21 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09624 — 68629

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: N/A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 159 N. Dean
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: COVERT — Middle: M. — Last: KELLY
4. DATE OF DEATH: Month: July — Day: 23 — Year: 19 67

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11 July 1935
9. AGE (In years last birthday): 32 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier
10b. KIND OF BUSINESS OR INDUSTRY: US Army
11. BIRTHPLACE (County & State, or foreign country): Coalport, PA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Deceased
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) 23Mar54-23Jul67
16. SOCIAL SECURITY NO: 188266004
17. INFORMANT: US ARMY PERSONNEL RECORDS — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO
(b): Arterosclerosis, Coronary Arteries, Marked.
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4211

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (My associate) attended the deceased from 23 July, 1967, to 23 July, 19 67 that (I) (We) last saw the deceased alive on DOD 23 Jul 19 67, and that death occurred at 1035 AM, from causes and on the date stated above

22a. SIGNATURE: Curtis I. Johnson Jr. M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): CURTIS I. JOHNSON, CPT, MC
22d. ADDRESS: Kirk Army Hospital, APG, Md.

23a. BURIAL, (CREMATION, REMOVAL (Specify)): Burial
23b. DATE THEREOF: July 29, 1967
23c. NAME OF CEMETERY OR CREMATORY: Glen Eden Cemetery
23d. LOCATION (City or Town) (County) (State): Livonia, Michigan

24. FUNERAL DIRECTOR: Lee A. Patterson & Son — ADDRESS: Perryville, Md.
Lee A Patterson & Son Perryville Md
RECD BY REGISTRAR DATE: JUL 28 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

39625 39625

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): none

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
d. STREET ADDRESS: Old Forge Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ALVIN — Middle COLLINS — Last LYON

4. DATE OF DEATH: Month JULY — Day 10 — Year 19 67

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Male	White		July 13, 1891	75 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Gen. Foreman	Railroad	Tennessee	USA

13. FATHER'S NAME: Matthew Hillsman Lyon

14. MOTHER'S MAIDEN NAME: Addie Glover

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO.	17 INFORMANT Address
No	700-09-0179	Mrs. Helen T. Lyon, Street, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Arteriosclerosis of the Stomach c. metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 151x

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or Town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept, 19 65, to July, 1967, that (I) (~~we~~) last saw the deceased alive on June 15 19 67, and that death occurred at 1 Pm, July 10, 1967 from causes and on the date stated above.

22a. SIGNATURE: M. Sadowsky M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b DATE SIGNED: 7/12/67

22c. PHYSICIAN'S NAME (Type): M. Sadowsky, M.D.

22d. ADDRESS: 504 Lewis St., Havre de Grace, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Removal	July 11, 1967	Fox Funeral Home	Bluff City, Tenn.

24 FUNERAL DIRECTOR ADDRESS: Howard V. McComas & Son, Abingdon, Md. 21009

25a REC'D BY REGISTRAR DATE: JUL 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09626

CERTIFICATE OF DEATH

09631

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural White Hall
c. LENGTH OF STAY IN 1b: Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Rural White Hall
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: James — Middle: Harold — Last: Miller

4. DATE OF DEATH: Month: Jult — Day: 18, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/16/1944

9. AGE (In years last birthday): 23 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State or foreign country): York, Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harold C. Miller

14. MOTHER'S MAIDEN NAME: Sara Shrodes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT — Address: Mrs. Sara Miller, Stewartstown, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Heart failure, pul. embolism
DUE TO (b): Rheumatic heart disease & endocarditis
DUE TO (c): Mental retardation
414X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 11, 1967, to July 18, 1967 that (I) (we) last saw the deceased alive on July 17, 1967 and that death occurred at 11:20 AM, from causes and on the date stated above.

22a. SIGNATURE: Norman H. Gemmill — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: July 18, 1967.

22c. PHYSICIAN'S NAME (Type): Norman H. Gemmill

22d. ADDRESS: Stewartstown, Penna.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/21/67

23c. NAME OF CEMETERY OR CREMATORY: Norrisville Cemetery

23d. LOCATION (City or Town) (County) (State): Norrisville, Harford Co. Md

24. FUNERAL DIRECTOR: Kenneth W. Rusburn — ADDRESS: Stewartstown, Pa

25a. REC'D BY REGISTRAR — DATE: JUL 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Yingling

1

09627

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03632

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 49 Monroe St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ida — Middle: Viola — Last: Murphy
4. DATE OF DEATH: Month: July — Day: 26 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 13 Jan. 1895
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Harford County, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: David Richard Kennard
14. MOTHER'S MAIDEN NAME: Mamie Rebecca Butler
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mildred V. Murphy, Aberdeen, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b): Arteriosclerotic Heart disease — 1 yr
DUE TO (c): Arteriosclerosis generalized
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-13, 1967 to 7-26, 1967 that (I) (we) last saw the deceased alive on 7-26 1967, and that death occurred at 12:45 PM, from causes and on the date stated above.

22a. SIGNATURE: Irvin L. Wachsman M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Irvin L. Wachsman, M.D.
22d. ADDRESS: Havre de Grace, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 29 July 67
23c. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery
23d. LOCATION (City or Town) (County) (State): Aberdeen, Maryland
24. FUNERAL DIRECTOR: Chester Macauley Sr. — Tarring Funeral Home, Aberdeen, Maryland
25a. RECD BY REGISTRAR DATE: JUL 31 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09628

CERTIFICATE OF DEATH

35633

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: Box 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: Murray

4. DATE OF DEATH: Month: July — Day: 31 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 29, 1893

9. AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: V. A. Hospital, Perry Point Md

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William J. Murray

14. MOTHER'S MAIDEN NAME: Mary E. Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: 220-44-5575

17. INFORMANT: Address: Mrs. Murray, Mrs. Castle, Colora[illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema due to — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): advanced a.s.c.v.d
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Uremia due to same and hypertrophied prostate. — 3-4 mo

4271

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-26, 1967, to 7-31, 1967, that (I) (we) last saw the deceased alive on 7-31 1967, and that death occurred at 3:30 P.M., from causes and on the date stated above

22a. SIGNATURE: [signature] M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: July 31-67

22c. PHYSICIAN'S NAME (Type): HENRY H. KWAK

22d. ADDRESS: 608 S. Union Ave, Havre De Grace

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 2 1967

23c. NAME OF CEMETERY OR CREMATORY: Graceland Cemetery

23d. LOCATION (City or Town) (County) (State): Darlington Md.

24. FUNERAL DIRECTOR: [signature] — ADDRESS: [illegible]

25a. RECD BY REGISTRAR DATE: AUG 7 1967

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial cremation, or removal, and in any event within 72 hours after death.

VR A-11ME (5) 6M 6/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

39629 (39621)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Maryland~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): M Aberdeen
d. STREET ADDRESS: Box 364
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GENE; Middle: ALFRED; Last: NAMETH

4. DATE OF DEATH: Month: July; Day: 19; Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 17, 1926

9. AGE (In years last birthday): 40 yrs

IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Vulcan Materials

11. BIRTHPLACE (State or foreign country): Havre de Grace

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Nameth

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 220-14-3837

17. INFORMANT: Betty Jane Nameth — Address: Box 364 Aberdeen Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Poisoning Due to CO.
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Piped exhaust fumes into car

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 7-19 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Craig Co. Rd

20f. (City or town) (County) (State): Darlington Har. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C. Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street city, town, or county)

22. DATE SIGNED: 7-19-67

23a. BURIAL, CREMATION, REMOVAL (Specify):

23b. DATE THEREOF: 7/23/67

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill

23d. LOCATION (City or Town) (County) (State): Havre de Grace Md.

24. FUNERAL DIRECTOR: Timmy Lee Dm — ADDRESS: Havre de Grace Md.

25a. REGISTRAR — DATE: JUL 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09630

CERTIFICATE OF DEATH

C3835

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
d. STREET ADDRESS: Lady Bird Forest
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: Foster — Last: Peirce
4. DATE OF DEATH: Month: July — Day: 17 — Year: 1967

5 SEX: Male
6 COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 3, 1868
9. AGE (In years last birthday): 99 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): College President
10b KIND OF BUSINESS OR INDUSTRY: Education - Prof.
11. BIRTHPLACE (County & State, or Foreign country): Mass.
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Levi Peirce
14 MOTHER'S MAIDEN NAME: Mary Foster

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16 SOCIAL SECURITY NO: 220-44-2367
17 INFORMANT Address: Mrs. Edith C. Peirce, Abingdon, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): A.S.C.V.D. — 3 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d INJURY OCCURRED White at work ☐ Not White at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from July 9, 1967, to July 17, 1967, that (I) (we) last saw the deceased alive on July 17, 1967, and that death occurred at 12 PM, from causes and on the date stated above.

22a SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7/17/67
22c PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: July 17, 1967
23c NAME OF CEMETERY OR CREMATORY: Greenmount Crematory
23d LOCATION (City or Town) (County) (State): Baltimore Md.

24. FUNERAL DIRECTOR ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009
25a. REC'D BY REGISTRAR DATE: JUL 19 1967
25b REGISTRAR'S SIGNATURE: J. Charles Jagger

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09631 — 09636

FOR STATE HEALTH DEPT. USE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1302 Churchville Rd

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 1302 Churchville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Mary — Middle: Alice — Last: Roe
4 DATE OF DEATH: Month: July — Day: 25 — Year: 1967
5 SEX: F
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 10/15/1881
9 AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered nurse
10b KIND OF BUSINESS OR INDUSTRY: Nursing
11 BIRTHPLACE (State or foreign country): Forest Hill, Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: William Roe
14 MOTHER'S MAIDEN NAME: Isabelle Curry

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ---
16 SOCIAL SECURITY NO: 216-18-9753
17 INFORMANT: Mrs. Mary R. Holloway — Address: 1302 Churchville Road Bel Air, Md. 21014

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic CV Disease — INTERVAL BETWEEN ONSET AND DEATH
4221
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C Palmer MD
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county): Bel Air Md
22. DATE SIGNED: 7-25-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7/28/1967
23c NAME OF CEMETERY OR CREMATORY: Centre
23d LOCATION (City or Town) (County) (State): Forest Hill, Maryland

24 FUNERAL DIRECTOR — ADDRESS: Charles E. Kurtz — Jarrettsville, Md. 21084
25a RECD BY REGISTRAR — DATE: JUL 27 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 7/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

39632 39637

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
d. STREET ADDRESS: Rt 2 Box 113
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lucy — Middle: M. — Last: Scarborough
4. DATE OF DEATH: Month: July — Day: 4 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/2/1881
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Fountain Green, Md.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: James Chamberlain
14. MOTHER'S MAIDEN NAME: Laura Forwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No ---
16. SOCIAL SECURITY NO.: 218-54-0795
17. INFORMANT: Oliver Scarborough — Address: RD #2 Box 113 Street, Md. 21154

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Pneumonia.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 16, 1967, to July 4, 1967, that (I) (we) last saw the deceased alive on July 4 1967, and that death occurred at 10:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: George J. Demorium M.D. — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7/8/1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion
23d. LOCATION (City or Town) (County) (State): Fountain Green, Maryland

24. FUNERAL DIRECTOR: Charles E. Kurtz — ADDRESS: Jarrettsville, Md. 21084
25a. RECD BY REGISTRAR DATE: JUL 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Snyder

1

09633

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09628

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HARRE DE GRACE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
d. STREET ADDRESS: Hookers Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: -- — Last: Singleton

4. DATE OF DEATH: Month: July — Day: 8 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 7, 1872

9. AGE (In years last birthday): 95 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (County & State or foreign country): Churchville, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 219-22-4061

17. INFORMANT: Mrs. Herbert T. Singleton, Hookers Mill Road — Address: Abingdon, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intra-abdominal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Chronic lymphatic leukemia — 3-4 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): A. S. C. V. D.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/7, 1967 to 7/8, 1967 that (I) (we) last saw the deceased alive on July 8, 1967, and that death occurred at 3:15 P.M. from causes and on the date stated above

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 7/8/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D. — 22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: July 11, 1967 — 23c. NAME OF CEMETERY OR CREMATORY: Darlington Cemetery — 23d. LOCATION (City or Town): Darlington (County): Harford (State): Md

24. FUNERAL DIRECTOR — ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009

25a. REC'D BY REGISTRAR DATE: JUL 11 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09634 — 5629

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove common papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural White Hall
c. LENGTH OF STAY IN 1b: Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural White Hall
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Wallace — Middle: L. — Last: Smithson

4. DATE OF DEATH: Month: July — Day: 8, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 12/12/1922

9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roy A. Smithson

14. MOTHER'S MAIDEN NAME: Emma Webb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO: 177-26-6415

17. INFORMANT: Mrs. M.R. Smithson, White Hall, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinomatosis, primary
DUE TO (b): in lungs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1967, to July 8, 1967 that (I) (we) last saw the deceased alive on July 7, 1967, and that death occurred at 3AM M, from causes and on the date stated above.

22a. SIGNATURE: Norman H. Gemmill M.D. ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 7/8/67

22c. PHYSICIAN'S NAME (Type): Norman H. Gemmill

22d. ADDRESS: Stewartstown, Penna.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jul. 11, 1967

23c. NAME OF CEMETERY OR CREMATORY: St. Paul Meth. Cem.

23d. LOCATION (City or Town) (County) (State): Pylesville, Harford Co., Md.

24. FUNERAL DIRECTOR: Kenneth W. Osborn

ADDRESS: Stewartstown, Pa.

25a. REC'D BY REGISTRAR DATE: JUL 10 1967

25b. REGISTRAR'S SIGNATURE

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

29535 — 35840

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 300 Bourbon St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

NAME OF DECEASED (Type or print): First: Edith — Middle: Myette — Last: Sutor

4. DATE OF DEATH: Month: July — Day: 31 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 11, 1883
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (County & State, or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Tyson
14. MOTHER'S MAIDEN NAME: Elizabeth Humphrey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 218-32-8908
17. INFORMANT: John F. Sutor, Jr. — Address: 300 Bourbon St. Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b): arteriosclerosis generalized
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/28/67, 19__, to 7/31, 1967 that (I) (we) last saw the deceased alive on 7/31/67 19__, and that death occurred at 1:55 P.M., from causes and on the date stated above.

22a. SIGNATURE: Edmund L. McDonough M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/31/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 3, 1967
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cem.
23d. LOCATION (City or Town) (County) (State): Havre de Grace Harford Md.

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: Havre de Grace, Md.
25a. REGD. BY REGISTRAR — DATE: AUG 4 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09636 — 03641

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Belcamp
d. STREET ADDRESS: Box 242
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virgie — Middle: Leona — Last: Taylor
4. DATE OF DEATH: Month: 7 — Day: 3 — Year: 19 67
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 30, 1909
9. AGE (In years last birthday): 57 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Ark.
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Sedley Sexton
14. MOTHER'S MAIDEN NAME: Thelma Sexton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 230-36-9203
17. INFORMANT: Address: Harold J. Taylor, White Marsh, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis (hepatic - abdominal) — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Carcinoma of Gall bladder — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus, Ascites, Inanition
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 4:45 P.M., from causes and on the date stated above

22a. SIGNATURE: A.W. Grigoleit M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/5/67
22c. PHYSICIAN'S NAME (Type): A.W. GRIGOLEIT
22d. ADDRESS: HAVRE de GRACE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 5, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Bel Air, Harford, Md

24. FUNERAL DIRECTOR — ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009
25a. RECD BY REGISTRAR DATE: JUL 6 1967
25b. REGISTRAR'S SIGNATURE: Jeanette Junge

Item 18 Film 391 7-28-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

39637 — 3842

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace

c. LENGTH OF STAY IN 1b: 14 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

d. STREET ADDRESS: P.O. Box 38

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: Anderson — Last: Trago

4 DATE OF DEATH: Month: July — Day: 18 — Year: 1967

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 9, 1912

9 AGE (In years last birthday): 55 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrican

10b KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11 BIRTHPLACE (County & State, or foreign country): HARFORD COUNTY, MD.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: A. LINN TRAGO

14 MOTHER'S MAIDEN NAME: REBECCA ANDERSON

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: 220-03-0054

17 INFORMANT — Address: Frances Trago, Churchville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lymphoma, ~~pleomorphic~~
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): reticulum cell sarcoma type
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Adenocarcinoma rectum

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 4, 1967, to July 18, 1967 that (I) (we) last saw the deceased alive on July 18 1967, and that death occurred at 6:20 A.M., from causes and on the date stated above

22a SIGNATURE: James McC. Finney, M.D. — M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 7-18-67

22c PHYSICIAN'S NAME (Type): James McC. Finney MD

22d ADDRESS: Churchville, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 20 July 67

23c NAME OF CEMETERY OR CREMATORY: Churchville Presbyterian

23d LOCATION (City or Town) (County) (State): Churchville, Md.

24 FUNERAL DIRECTOR: Melvin Macomber Sr. — ADDRESS: Tarring Funeral Home, Aberdeen, Maryland

25a. RECD BY REGISTRAR DATE: JUL 21 1967

25b. REGISTRAR'S SIGNATURE: Charles Jorge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

99638

CERTIFICATE OF DEATH

C3644

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: Box 169, Harford Convalescent Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Edward — Last: WALTER

4. DATE OF DEATH: Month: 7 — Day: 2 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 16, 1907

9. AGE (In years last birthday): 60 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner-Operator

10b. KIND OF BUSINESS OR INDUSTRY: Convalescent Home

11. BIRTHPLACE (County & State, or foreign country): Balto. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Edward Walter

14. MOTHER'S MAIDEN NAME: Elizabeth Lee Temple

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW #2

16. SOCIAL SECURITY NO.: 218-09-8055

17. INFORMANT (Name): Mrs. Jessie Lee Walter (wife) 838-7220 — Address: RFD #1, Box #169 Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRAIN ABSCESSES — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Pneumonitis — 6 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from May 15, 1967, to July 2, 1967, that (I) (we) last saw the deceased alive on 7-2-1967, and that death occurred at 7:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: Louis Hinds M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-3-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 5, 1967

23c. NAME OF CEMETERY OR CREMATORY: Mt. Tabor Meth. Ch. Cem.

23d. LOCATION (City or Town) (County) (State): Bel Air, Harford Co., Maryland

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25a. REC'D BY REGISTRAR DATE: JUL 6 1967

25b. REGISTRAR'S SIGNATURE: James Yingling

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09639

CERTIFICATE OF DEATH

03645

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace,
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 666 Green Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: UNA — Middle: V — Last: WARING
4. DATE OF DEATH: Month: July — Day: 28 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 16 Feb. 1894
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher (Ret)
10b. KIND OF BUSINESS OR INDUSTRY: Public Schools
11. BIRTHPLACE (County & State, or foreign country): Harford County, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles M. Grafton
14. MOTHER'S MAIDEN NAME: Emma Virginia Minnick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 212-38-4400
17. INFORMANT: Address: Virginia Bull, Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH: 4 dys
DUE TO (b): Acute Peritonitis — 4 dys
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
576.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-23, 19 67 to 7-28, 19 67, that (I) (we) last saw the deceased alive on 7-28- 19 67, and that death occurred at 2:58 P.M., from causes and on the date stated above.

22a. SIGNATURE: Irvin L. Wachsman M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 28 July 1967
22c. PHYSICIAN'S NAME (Type): Irvin L. Wachsman, M.D.
22d. ADDRESS: Havre de Grace, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 31 July 67
23c. NAME OF CEMETERY OR CREMATORY: Deer Creek Meth. Cemetery,
23d. LOCATION (City or Town) (County) (State): Forest Hill, Md.

24. FUNERAL DIRECTOR: Jarring Funeral Home,
ADDRESS: Aberdeen, Md.
25a. REC'D BY REGISTRAR DATE: AUG 1 1967
25b. REGISTRAR'S SIGNATURE: Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 10

09650

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05646

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH — a. COUNTY: Harford. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 9 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d. STREET ADDRESS: 1604 Holly Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Earl — Last: Warner.
4. DATE OF DEATH — Month: 7 — Day: 23 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 14, 17
9. AGE (In years last birthday) yrs.: 49
IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer.
10b. KIND OF BUSINESS OR INDUSTRY: Harford Metal Products
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Warner.
14. MOTHER'S MAIDEN NAME: Nellie Adams.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 215-16-5298
17. INFORMANT — Address: Mrs. Hallonie B. Warner, 1604 Holly Drive Joppa Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute subacute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b): Thrombotic occlusion of anterior descending and right coronary artery — 1 day
DUE TO (c): Hypertensive arteriosclerotic heart disease — 15 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-23, 1967 to 7-23, 1967 that (I) (we) last saw the deceased alive on 7-23 1967, and that death occurred at 9:05 P.M., from causes and on the date stated above.

22a. SIGNATURE: Richard J. Colfer M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 7/24/67
22c. PHYSICIAN'S NAME (Type): Richard J. Colfer M.D.
22d. ADDRESS: Harford Memorial Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 27/67
23c. NAME OF CEMETERY OR CREMATORY: Lorraine Park
23d. LOCATION (City or Town) (County) (State): Bel Air Md.
24. FUNERAL DIRECTOR — ADDRESS: Leroy Eugene 8728 Liberty Road Randallstown
25a. REC'D BY REGISTRAR — DATE: JUL 27 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Yingling

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (II)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09641

CERTIFICATE OF DEATH

09647

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 8
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen 12-1 RURAL
d. STREET ADDRESS: Churchville Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IRMA; Middle: C; Last: Welsh

4. DATE OF DEATH: Month: July; Day: 20; Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 14, 1882

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Hanover, Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Atzrodt

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-24-7987

17. INFORMANT: Evelyn L. Gilley, Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-Vascular Accident
DUE TO (b): Hypertensive-Arteriosclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).: Aortic Stenosis with relative Mitral Insufficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-13, 1967 to 7-20, 1967, that (I) (we) last saw the deceased alive on 7-20 1967 and that death occurred at 1:00 M, from causes and on the date stated above.

22a. SIGNATURE: John Lynch M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/20/67

22c. PHYSICIAN'S NAME (Type): JOHN D. LYNCH

22d. ADDRESS: HAVRE DE GRACE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 23 July 67

23c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery

23d. LOCATION (City or Town) (County) (State): Hanover, Penna.

24. FUNERAL DIRECTOR: Walter Macomber Sr.

ADDRESS: Tarring Funeral Home Aberdeen, Maryland

25a. REC'D BY REGISTRAR DATE: JUL 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09642

CERTIFICATE OF DEATH

Item #8 Film #3391 8/16/67 ph

1.1089

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 211 S Main St

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: Bond St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: — Last: Williams

4. DATE OF DEATH: Month: July — Day: 28 — Year: 1967

5. SEX: Mal

6. COLOR OR RACE: Col

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 3-15-1900

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Harford Co

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Franklin Williams

14. MOTHER'S MAIDEN NAME: Anna Jemeson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 212-20-8757

17. INFORMANT: Howard Jackson — Address: Bel Air Md Bond St

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic CV Disease — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED — While at work ☐ — Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 1-1, 1965, to 7-28, 1967, that (I) (we) last saw the deceased alive on 7-28 1967, and that death occurred at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Gerald E Palmer M.D.

22b. DATE SIGNED: 7-28-67

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Gerald E Palmer MD

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-2-67

23c. NAME OF CEMETERY OR CREMATORY: Clark Chapel

23d. LOCATION (City, town or county) (State): Bel Air Harford Md

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: George W Tittle Bel Air Md

25a. REC'D BY REGISTRAR — DATE: AUG 14 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62